Northside Pediatrics, P.C.

CHILD'S NAME_____ DATE OF BIRTH_____ SEX____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

CHILD'S SS#_____

FATHERS INFORMATION

NAME_____

ADDRESS_____

SS#_____

DATE OF BIRTH_____

HOME PHONE_____

WORK PHONE_____

PLACE OF EMPLOYMENT_____

NAME OF INSURANCE FOR CHILD

_____

INSURANCE #'S

_____

MOTHERS INFORMATION

NAME_____

ADDRESS_____

SS#_____

DATE OF BIRTH_____

HOME PHONE_____

WORK PHONE_____

PLACE OF EMPLOYMENT_____

INSURANCE FOR CHILD

_____

INSURANCE #'S

_____

MEDICAID #'S FOR CHILD_____

NEAREST RELATIVE_____ RELATIONSHIP TO PATIENT_____

ADDRESS OF RELATIVE_____ PHONE # OF RELATIVE_____

FRIEND OR NEIGHBOR_____ PHONE OF FRIEND_____

EMERGENCY CONTACT NAME AND NUMBER_____

OTHER CHILDREN IN FAMILY

NAMES	DATE OF BIRTH
_____	_____
_____	_____
_____	_____
_____	_____

SIGNATURE OF PARENT/GUARDIAN

_____

TODAY'S DATE

_____

DIVORCED PARENTS: IT IS THE POLICY OF THIS OFFICE THAT THE PARENT BRINGING THE CHILD FOR TREATMENT WILL BE HELD RESPONSIBLE FOR THE BILL. WE CANNOT BILL THE OTHER PARENT. IF SOMEONE OTHER THAN YOURSELF I S RESPONSIBLE FOR THE PAYMENT OF THE BILL, IT IS YOUR RESPONSIBILITY TO SEE THAT THE PARTY RECEIVES A COPY OF THE BILL.

Welcome to Northside Pediatrics, P.C.

When a patient first comes to our office there will be paperwork that will be required to be completed by a parent or a legal guardian. This parent or legal guardian will be considered the patient's representative and guarantor. On occasion, an existing patient will also be asked to update paperwork if it is determined that the current paperwork is out-dated. It is necessary to keep our records as current as possible to ensure we may reach you if needed.

You may be asked to present your current insurance card for verification. If you receive a new card from your insurance company, please ensure we receive a copy when you come to our office. If there is more than one insurance for the child, it is the subscriber's responsibility to ensure we are billing insurances in the proper order. Please be sure to let the receptionist know which insurance is considered primary. If an insurance policy is terminated or changed in any way, please let us know to avoid unnecessary personal bills.

If your insurance company requires a co-payment, it must be paid on the date of service. The co-payment will be expected regardless of who brings the patient. If you are unable to pay a co-payment on the date of service, please contact the billing department prior to your appointment to make arrangements. Any balance that your insurance company does not cover after claim submission, will be your responsibility. Medicaid coverage is verified at each visit. If Medicaid states that the patient is not eligible, the patient will be considered uninsured. The guarantor will assume full financial responsibility for services rendered when the patient is uninsured.

We do monitor past due accounts and use a collection agency to assist in debt recovery, however, we would prefer to work directly with our patients regarding debt. Payment plans are available by contacting the billing department. We also accept credit cards for your convenience. Outstanding account balances may result in discharge from practice.

Initial

We do not charge for missed appointments, however, appointment compliance policies are in place. If a family misses multiple appointments, the entire family may be discharged from practice.

We do charge a fee for copying records, faxing, and completing miscellaneous forms. Any questions regarding these charges, please contact the billing office.

I have read and understand the above policies.

_____
Patient Representative-Please Print

_____ Date_____
Patient Representative- Signature

_____ DOB_____
Patient's Name

PATIENT CONSENT FORM

By signing this form, you are giving consent to Northside Pediatrics, P.C. to use and disclose your protected health information for the purposes of treatment, payment, and health care operations. Our Notice Of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage that you read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by calling the office, 269-962-6221, and if a revision has been done you may pick one up or we will mail you one upon request.

You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment, or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we have already used or disclosed your protected health information in reliance on your consent.

Signature:_____ _____

of Patient Representative — Relationship of Patient Representative to Patient

_____ _____

Signature or Name of Patient — Date

PF-2000 Acknowledgement of Receipt of Notice of Privacy Practices

Northside Pediatrics P.C. reserves the right to modify the privacy practices outlined in the notice.

Signature

I have received a copy of the Notice of Privacy Practices for Northside Pediatrics.

_____

Name of Patient (Print or Type)

_____

Signature of Patient

_____

Date

_____

Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form)

_____

Relationship of Patient Representative to Patient

Standard Authorization of Use and Disclosure of Protected Health Information and Consent For Treatment

Information to Be Used or Disclosed
The information covered by this authorization includes: **ALL**_____

OTHER: _____

Purposes of Disclosure

Information listed above will be disclosed for the following purposes:

TREATMENT PAYMENT DAY TO DAY OPERATIONS

Entity Authorized to Use or Disclose Information
Information listed above will be used or disclosed by:

NORTHSIDE PEDIATRICS, P.C.

Persons to Whom Information May Be Disclosed and Consent For Treatment For My Minor Child In My Absence For Routine Care, Immunizations and/or Emergency Care:

_____
Name of person/Relationship to Patient

_____
Name of person/Relationship to Patient

_____
Name of person/Relationship to Patient

Expiration Date of Authorization
This authorization is effective through ___/___/___ unless revoked or terminated earlier by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to Northside Pediatrics, P.C.. You should contact the Privacy Officer to terminate this authorization.

Potential for Re-disclosure
Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. It may not be possible to ensure your right to the protection of the privacy of this information once Northside Pediatrics, P.C. discloses it to another party.

Rights of the Individual

- ☐ You may refuse to sign this authorization.
- ☐ You may inspect or copy information used or disclosed under this refuse to sign this authorization.

Signature

_____
Signature of Patient Representative

_____
Relationship to Patient Date

_____
Name of Patient Date of Birth

Revised 4-29-03

Northside Pediatrics, PC
265 Fremont Street
Suite 1
Battle Creek, MI 49017
269-962-6221

Receipt of Notice of Privacy Practices

I, _____, hereby acknowledge receipt of the Notice of Privacy Practices . The Notice of Privacy Practices provide detailed information about how the practice may use and disclose my confidential information.
I understand that the practice has reserved a right to change its privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available.

Signed:_____ Date:_____

Patient's name_____

If you are not the patient, please specify your relationship to the patient

Mother_____
Father_____
Guardian____
Other_____ please fill in_____

Inability to Obtain Acknowledgment

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgment, describe the good faith efforts made to try and obtain the individual's acknowledgment, and the reasons why it was not obtained.
Signature of provider representative:_____ Date:_____

Reasons why the acknowledgment was not obtained
? Patient refused to sign
? Other or Comments

_____
_____
_____